

**APPENDIX 4d**  
**SAMPLE HCFA 1500 CLAIM FORM**  
**COMPREHENSIVE SCREEN**  
**LEAD TEST GIVEN - BILL LAB HANDLING FEE**  
**CLAIM SORT INDICATOR "P"**  
**RECEIVED BY THE FISCAL AGENT ON OR AFTER 2/15/95**  
**HEALTHCHECK NURSING AGENCY BILLER**

**HEALTH INSURANCE CLAIM FORM**

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>1234567890</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Recipient, Im A</b>		3. PATIENT'S BIRTH DATE MM DD YY <b>MM DD YY</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) <b>609 Willow St.</b>		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY <b>Anytown</b> STATE <b>WI</b>		7. INSURED'S ADDRESS (No., Street)  CITY  STATE  ZIP CODE <b>55555</b> TELEPHONE (INCLUDE AREA CODE) <b>(XXX) XXX-XXXX</b>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-Y</b>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER  b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME  d. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME  c. INSURANCE PLAN NAME OR PROGRAM NAME  d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. <b>V70 0</b> 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From To B. Place of Service C. Type of Service D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS CODE F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. EMG J. COB K. RESERVED FOR LOCAL USE			
04 01 95 3 1 99382 HC 1 XX XX 1			
04 01 95 3 5 99000 1 XX XX 1			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. <b>1234JD</b>	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>I.M. Authorized</b> MM/DD/YY SIGNED _____ DATE _____		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ <b>XXX XX</b> 29. AMOUNT PAID \$ 30. BALANCE DUE \$ <b>XXX XX</b>	
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>I. M. Billing</b> <b>1 W. Williams</b> <b>Anytown, WI 55555</b> PIN# _____ GRP# <b>87654321</b>	